



Interregional Patient Mobility in the Italian NHS: A Case of Badly-Managed Decentralization

Comment on “Regional Incentives and Patient Cross-Border Mobility: Evidence From the Italian Experience”

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Abstract

The article by Brenna and Spandonaro on interregional mobility for acute hospital care in Italy raises important issues concerning social and territorial equity in a healthcare system. Based on Regions and private providers' strategic behavior, the hypothesis adopted to explain patient cross-border mobility (CBM), demonstrated by statistical analysis, may be further explored using qualitative methods. In order to reduce CBM, the central government needs to play a more active role in coordination, even in a highly decentralized National Health Service (NHS).

Keywords: Patient Mobility, Italian National Health Service (NHS), Decentralization, Managed Competition, Patient Choice

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Citation: Neri S. Interregional patient mobility in the Italian NHS: a case of badly-managed decentralization: Comment on “Regional Incentives and patient cross-border mobility: evidence from the Italian experience.” *Int J Health Policy Manag.* 2015;4(12):857–859. doi:10.15171/ijhpm.2015.154

Article History:

Received: 12 June 2015

Accepted: 18 August 2015

ePublished: 25 August 2015

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Introduction

Patient cross-border mobility (CBM) is a phenomenon with important social and economic consequences. Although it has been extensively studied in international literature¹⁻⁴ further research is required. The article by Brenna and Spandonaro,⁵ dedicated to interregional mobility for acute hospital care in Italy, is an important contribution in this respect, as it raises critical issues that go well beyond the Italian case, concerning social and territorial equity as well as the role of central and regional government within a National Health Service (NHS) system.

Their analysis shows that the introduction of managed competition, based on patient choice and diagnosis-related groups (DRGs), led Northern and Central Regions to increase patient inflows coming from Southern Regions, thus worsening the traditional North-South divide and the social and territorial inequalities in the Italian NHS. This closely relates to what happened in the 1990s and 2000s when decentralization was implemented, now calling for the central government to play a more active role in governing a highly regionalized healthcare system.

NHS Regulation and Actors' Behavior: The Drivers of Patient Mobility

In their theoretical framework, Brenna and Spandonaro⁵ explain patient interregional mobility by considering the Regions' strategic behavior and the entrepreneurial behavior of private providers, which are both related to national NHS regulation and its implementation at Regional level. This framework is not common in literature, which does not usually consider these explaining factors. Literature does not explore the activity carried out by Regions and private providers in

promoting CBM mobility while using the healthcare system regulation; rather it is usually neglected or taken for granted. On the contrary, it plays a fundamental role in explaining patient interregional mobility.

As the authors illustrate, the 1992 national healthcare reform introduced managed competition,⁶ then converted into managed cooperation,⁷ based on patient freedom of choice, DRG-based tariffs and, since 1999, purchaser-provider contracts with overall ceilings, tariff caps, and cuts.⁸ These regulative devices represent the main institutional framework within which Regions, as well as public and private providers, perform strategies aimed at pursuing their goals and targets. Brenna and Spandonaro⁵ note the different ability shown by Northern and Southern Regions in implementing a well-provided and good quality Regional Health Service (RHS) through the accreditation system. Regional differences in the 1990s reform implementation have already been analyzed in the literature, focusing on the lack of “stateness” or “administrative capacity” by the Southern Regions as explaining factors.^{9,10}

However, the article considers these differences in the context of the mobility policy adopted by Regions. Northern and Central Regions use their high quality public and private services not only to respond to resident demands and needs, but also to balance their budget. For this purpose, they take advantage of the accreditation system and of purchaser-provider contracts in particular.

Purchaser-provider contracts (called “service agreements”) are usually considered as a tool to keep health expenditure under control, and their role is largely undervalued as they often represent the mere translation of Regional decisions on financial resource allocation, which public purchasers,

ie, Local Health Authorities, simply adopt without applying any substantial discretionary power. Instead, they may also be used to absorb excessive capacity and drain financial resources from the other Regions, as Regions with a high CBM positive balance do. Service agreement clauses may encourage hospitals to increase the services provided and the corresponding income, by addressing all their efforts to nonresident patients and therefore creating an induction effect. Incentives for entrepreneurial and opportunistic behavior are much stronger in private providers, who do not have access to Regional ex-post funding for any budget loss, as happens for public providers.

The hypothesis is demonstrated by a statistical analysis of CBM which distinguishes among different types of mobility (boundary versus distance mobility), different hospital categories (identifying mobility directed to high quality/excellence centers and to other hospitals) and nature of the provider (public versus private hospitals). Moreover, the statistical analysis is corroborated by the documentary analysis of Regional service agreements, as well as by some evidence on private provider entrepreneurial behavior.

However, documentary analysis is only briefly outlined and the evidence related to private providers is simply quoted by other studies. Further research could be carried out by applying Brenna and Spandonaro's contribution and therefore seeking confirmation of the article's hypothesis using qualitative methods. Documentary analysis of the purchaser-provider contracts as well as other relevant regulation mechanisms could be matched with interviews to Regional ministers and managers, private providers and any other subject who could lead to better understanding of drivers, features and consequences of patient mobility.

Patient Cross-Border Mobility and the Governance of a National Health Service

According to the authors, interregional mobility trend did not diminish in the period 2000-2010; data analysis performed for 5 Regions with high inflow patient rates reports an increase in CBM from 2009-2011. Bearing in mind that, in most recent years, the difficult financial situation of many Southern Regions, along with the austerity policy caused by the economic and financial crisis, has led to cuts in service provision and capacity in many of the Regions with high patient outflows, we may expect mobility from Southern to Northern Italy to be actually increasing. Consequently, social and territorial inequalities linked to CBM have not diminished in the past decade and are now probably worsening, thus contributing to the general increase of the NHS historical North-South divide, in terms of service efficiency, access and quality.¹¹

When NHS regionalization was approved and initiated, the general expectation was that it would have triggered a reduction in the traditional territorial inequalities. Managerial autonomy and financial responsibility, especially after 2000 tax reform, would have caused Regions with inefficient and low quality services to improve their Regional healthcare system by reducing service access and quality disparities. CBM regulation, based on a flat, DRG-specific and very expensive tariff, was a crucial part of this framework. On one hand, there are Regions with high patient outflows

and negative mobility rate that pay for both their internal inefficiencies – hospitals with underutilized capacity and not completely covered fixed costs – and their patients' expensively financed "escape." On the other hand, Regions with high patient inflows and positive mobility rate benefit from good quality hospital systems meeting economies of scale and draining financial resources from the other Regions thanks to a small degree of outflows. Having a high level of patient outflows, CBM regulation should have prompted Southern Regions to arrange a good quality hospital system for acute care in order to reduce interregional patient mobility and consequently widen the historical gap with the Northern Regions. Evidence from literature and from this article shows that this did not happen. North-South inequalities in service access and quality have not reduced and probably have increased after regionalization,¹¹ while CBM remained stable or even increased.

Reasons for Southern Regions' failure in reducing outpatient inflows and healthcare inequalities in general compared to Northern Regions is mainly due to how the Italian NHS was regionalized in the last 2 decades, as Brenna and Spandonaro suggest. After 1992 and subsequent reform programs, implementation of the accreditation system and of most of the organizational and regulation arrangements necessary to set up the RHSs were autonomously carried out at Regional level. Any form of planning, coordination or supervision by the Ministry of Health (MoH) and central government were substantially lacking in this process; as a result, differences in Regional administrative and governance capacity were emphasized and this reflected in the RHS organization and regulation. As regards mobility, no equitable allocation of hospital services was ensured, neither was uniformity in managing this issue at Regional level.

The shift from managed competition to managed cooperation in 1999 minimized incentives for competition within each single Region⁸ but preserved them at interregional level. This process created favorable conditions for Northern Regions, boasting high quality hospital systems and higher administrative capacity, to carry out explicit or implicit CBM policies aimed at drawing resources from Southern Regions – with low quality hospital systems and lower administrative capacity. After this shift from managed competition to managed cooperation within each individual Region, private providers had more incentives to develop strategies for attracting patients from other Regions and Northern Regions supported this attitude. As a result, only apparently paradoxical, interregional competition among Regions replaced infra-regional competition.

If there is a shared opinion that CBM has to be significantly reduced, improving equity among citizens resident in different parts of Italy and, at the same time, promoting a new equilibrium in the real allocation of financial resources, central government is called to play a more active role in the NHS governance. The MoH should increase its widely neglected coordination and improve its steering role among Regions, as it seemed to have begun with the new "Pact for Health" signed in 2014. This new attitude should be broadly expressed in the State-Regions conference, namely the main Italian NHS joint-governing body.¹² In this context, central government should foster interregional agreements,

mentioned by the authors and strongly recommended by us, and should incentivize and subsidize new investments in personnel, advanced technology and specialization within the hospital sector in the Southern Regions.

Central government role looks crucial in managing the mobility phenomenon and in leveling healthcare inequalities between South and North. This seems to be true even in a decentralized healthcare system such as the Italian one. More than 20 years of decentralization showed that highly autonomous Regions, if left alone, are not able to solve these critical issues but rather tend to worsen them. This is a lesson that any policy-maker of any country, operating at national or subnational level, must learn.

At the European level, Directive 2011/24 on the application of patient rights in cross-border healthcare provides important tools to manage patient mobility among European Union (EU) members, supporting the regulation of CBM, promoting cooperation among countries, clarifying responsibilities of member states, specifying patient rights and reimbursement rules as well as the possibilities for the member states to limit patient mobility, more clearly than in the past.¹³ Being more optimistic than Brenna and Spandonaro, and although some limits in the framework create difficulties in implementation, we can argue that the Directive provides the ground to national policy-makers and healthcare managers and professionals to reach an adequate regulation and management of patient mobility at EU level.

Ethical issues

Not applicable.

Competing interests

Author declares that he has no competing interests.

Author's contribution

SN is the single author of the manuscript.

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